

REHABILITATIVE RESOURCES, INC.  
INDIVIDUALIZED SEIZURE PROTOCOL

NAME \_\_\_\_\_ DOB \_\_\_\_\_

TYPE OF SEIZURE \_\_\_\_\_ DURATION \_\_\_\_\_

LAST SEIZURE \_\_\_\_\_

DESCRIPTION \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CALL EMS (911)**

- If seizure last greater than \_\_\_\_\_ minutes (RRI policy 5 minutes)
- If the individual has one seizure after another **yes no**
- If there is a CHANGE in a seizure pattern **yes no**
- If the individual has been injured **yes no**
- If individual has a seizure who has an INACTIVE pattern (greater than one year) **yes no**
- Other or any changes to the above statements

\_\_\_\_\_  
\_\_\_\_\_

**CALL NEUROLOGIST**

- If the individual experiences \_\_\_\_\_ seizures in 24 hour period  
(Number)
- If the individual experiences \_\_\_\_\_ seizures in a week  
(Number)
- If the seizure last longer than \_\_\_\_\_ minutes
- If the individual has a seizure who has an INACTIVE pattern ( greater than one year) **yes no**
- If post seizure behavior ( confusion, agitation, decrease in activity etc.) continues longer than 30 minutes **yes no**

Additional  
Information \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_ HCP Signature \_\_\_\_\_